sharecare

Date: __ __/__ __ /__ __ __ __

Request for Form Completion

Phone: 866-273-4039 | Fax: 866-570-0729

Pre- Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s).
The fee schedule is as follows:
$30 for initial form, $15.00 for updates for same qualifying condition, plus any applicable sales tax.
You will be contacted by Sharecare with payment options after you return this paperwork.

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_____

Patient Name:_____
(Last) (First) (Middle / Maiden)

Address:_____

City:_____ State:_____ Zip:_____

Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address(*Required)-:_____

Physician:_____ **Body Part:**_____

Date Injury/Problem Began:_____ **Last Day Worked:**_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_____

Please check a reason: ☐ Continuous Leave ☐ Surgery and Post-Op Treatment ☐ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work:_____

I authorize OrthoCarolina to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Fax #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address: _____

Please check your preferred method of release:

☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the OrthoCarolina Privacy Office and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by OrthoCarolina before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. ***This authorization will expire in 1 year or when I am released from my treating provider at OrthoCarolina.***

Signature:_____ Date:_____
(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____)